

Senate Passes Health Reform Bill

Highlights

- ✓ Individual and employer mandates for health insurance
- ✓ Small employer insurance credit
- ✓ Health insurance exchanges
- ✓ Tax on high-cost insurance
- ✓ Insurance market reforms
- ✓ Quality outcomes and Medicare payments
- ✓ Expansion of Medicaid eligibility
- ✓ Value-based purchasing for Medicare providers
- ✓ Medicare and Medicaid program integrity improvements

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The Senate passed its version of a sweeping overhaul of the nation's health insurance system, approving the "Patient Protection and Affordable Care Act" (H.R. 3590) in a dramatic Christmas Eve vote on December 24, 2009. As expected, the Act passed along party lines, with all 58 Democrats voting for the measure, while all Republicans present voted against it. The two independents who normally caucus with the Democrats—Bernie Sanders (I-VT) and Joe Lieberman (I-CT)—cast their votes for the measure, making the final tally 60-39.

The House passed its version of the health care overhaul (H.R. 3962) on November 7. Significant differences remain between the House and the Senate versions, including:

- Treatment of the public option;
- Minimum coverage requirements for employers;
- Revenue raisers to pay for the measure; and
- Coverage for abortion in the new health exchanges.

Democratic leaders contend that these differences will be ironed out in time for President Obama to sign the legislation early in 2010, perhaps before the State of the Union address, which is typically held in late January. Republicans have vowed to continue to block passage of the health overhaul.

Employers

Employer responsibility. The Senate bill does not require employers to provide health insurance coverage. However, the Senate bill mandates automatic enrollment in health insurance plans sponsored by large employers.

In addition, "large employers" (generally those with 50 or more employees) that fail to offer minimum essential coverage during any month for which a full-time employee has enrolled in a qualified plan and receives a premium assistance tax credit or cost-sharing reductions would be liable for an additional tax. That penalty would equal the product of the applicable payment amount (defined as, with respect to any month, 1/12 of \$750) and the number of full-time employees employed by the employer during such month.

Large employers offering coverage with employees who qualify for premium assistance tax credits or cost-sharing reductions would also be liable for an additional tax equal to the product of the number of full-time employees for the month and 400 percent of the applicable payment amount. Large employers with extended enrollment waiting periods (generally those exceeding 60 days) would be liable for an additional tax of \$600 for each full-time employee for whom the extended waiting period applies. Special rules would apply to construction employers.

Core Concepts

Although significant issues still need to be worked out before Congress passes a final bill, the core concepts that have emerged would fundamentally alter the health care landscape.

- All individuals would be required to obtain health care coverage or pay penalties. Employer-provided coverage would generally satisfy the universal-coverage requirement. Coverage would also be available via the establishment of “health insurance exchanges” through which individuals and some small businesses could select coverage from a menu of private plans. The House bill also includes a “public option” through which such coverage may be obtained; the Senate bill does not. Lower-income individuals would receive a credit or voucher to help pay for health insurance.
- Employers currently offering health insurance could elect to continue offering coverage as long as their plans meet certain acceptable minimum requirements. Employers electing not to offer qualifying coverage would be subject to additional taxes to help finance the health care coverage for their employees. Exceptions would be made for small business.

Comment: *The House bill requires employers to satisfy certain minimum coverage requirements. Generally, the “employer mandate” requires employers to contribute at least 72.5 percent of premium costs for individuals and 65 percent of premium costs for families. Employers that elect not to offer qualified coverage to their employees would be liable for an additional payroll tax of up to eight percent of the employee’s average annual salary. Small employers (generally employers with annual payrolls below \$500,000) would be exempt from the additional payroll tax. A graduated additional payroll tax (starting at two percent and rising to six percent) would apply to employers with annual payrolls between \$500,000 and \$750,000.*

Treatment of small businesses. The Senate bill provides a small employer credit. Starting in 2010, qualified small businesses would be eligible for tax credits

up to 35 percent. The credit would reach 50 percent by 2014. Salary-reduction contributions are not counted. A qualified small employer has 25 or fewer employees and pays average annual wages of \$40,000 or less. The amount of the credit is reduced for employers with 10 to 25 employees and average annual wages of \$20,000 to \$40,000 per employee. The wage threshold is indexed for inflation beginning in 2014. Tax-exempt employers would receive a 35 percent credit.

Comment: *The House bill provides a similar measure.*

Information returns. Under the Senate bill, employers and other entities providing minimum essential coverage would be required to file information returns with the IRS identifying the individual, the coverage and the amount of premium, if any, paid by the individual. Penalties would be imposed for failure to file an information return.

Flexible spending arrangements. The Senate bill caps flexible spending arrangement (FSA) contributions at \$2,500 (indexed for inflation). The bill also prohibits the use of FSA funds for over-the-counter medications. These changes would apply to distributions and reimbursements for taxable years beginning after December 31, 2010.

Comment: *The House bill would also cap annual contributions to a health FSA offered under an employer-sponsored cafeteria plan at \$2,500 (indexed for inflation).*

Comment: *Both the Senate and the House bills expressly include insulin as a covered expenditure.*

Health savings accounts. The Senate bill provides that individuals under age 65 must pay an additional tax for nonqualified distributions from a health savings account (HSA) and increases the additional tax from 10 percent to 20 percent. (The additional tax on Archer medical savings accounts would increase from 15 to 20 percent.)

Comment: *The House measure regarding HSAs is similar to the Senate measure.*

Cafeteria plans. The Senate bill would relax the cafeteria plan rules to encourage more small employers to offer tax-free benefits to employees, including those related to health insurance coverage. It does so by

carving out a safe harbor from the nondiscrimination requirements for cafeteria plans for qualified small employers.

Comment: *Under the House bill, coverage purchased through the Exchange could not be purchased on a pre-tax salary reduction basis.*

Executive compensation. The Senate bill amends Code Sec. 162(m) as it applies to remuneration paid by health insurance providers to high-level executives. Generally, no Code Sec. 162(m) deduction would be allowed to the extent the remuneration exceeds \$500,000, but note that special provisions are made for deferred compensation. The provision would apply for taxable years beginning after December 31, 2009 with respect to services performed after December 31, 2009.

Comment: *The House bill does not include a similar provision.*

Individuals

Health insurance exchanges. For individuals who are not currently covered by their employer (and some small businesses), both the House and Senate bills establish new Health Insurance Exchanges in which consumers can comparison shop among health plans. Note that while the House bill provides for the creation of a “public option” as one such plan, the Senate version does not include a similar provision.

Individual responsibility. The Senate bill would require individuals to maintain minimum essential coverage beginning after 2013. Individuals who fail to maintain minimum essential coverage would be liable for a penalty. The bill uses a formula to calculate the penalty taking into account the taxpayer’s household income and a flat dollar amount. Generally, the penalty would start at \$95 for 2014, \$495 for 2015 and \$750 for 2016 (with indexing for inflation for tax years after 2016).

Individuals with Medicare and other qualified government coverage would also satisfy the minimum essential coverage requirement.

The Senate bill would provide premium assistance tax credits and reduced cost sharing to qualified individuals. The amount of the premium assistance tax credit would be tied to the relation of the individual’s income to the federal poverty limit and would be adjusted for inflation. Generally, individuals who fall within 100 percent to 400 percent of the federal poverty limit would be eligible for

premium assistance. Premium assistance tax credits would be disregarded for federal or federally-assisted programs.

Certain exclusions from the individual minimum coverage requirement are provided. The Senate bill excludes undocumented individuals in the U.S. from coverage and provides special rules for children under age 18 and incarcerated individuals. Additionally, individuals who cannot afford coverage (generally where the individual’s required contribution would exceed eight percent of household income for the taxable year), individuals with taxable income under 100 percent of the federal poverty limit, qualified members of Native American tribes, and certain hardship cases would be exempt.

Comment: *The House bill would generally require all individuals to get coverage, either through their employer or the Exchange. Individuals without acceptable health care coverage would pay an additional tax, subject to a hardship exemption. The additional tax could equal as much as 2.5 percent of the taxpayer’s modified adjusted gross income that exceeds the taxpayer’s applicable exemption amount plus the standard deduction for the year. Under the measure, low-income individuals would be provided with “affordability credits” to help pay for the cost of coverage purchased through the Exchange.*

Funding Mechanisms

The Senate and House bills each take different approaches to generating additional revenue in order to pay for the health care overhaul.

The Senate bill would impose both a (1) new tax on high-cost group insurance and (2) an additional Medicare payroll tax on high-income taxpayers. Annual nondeductible fees on various health-related industries are also imposed, as well as a 10 percent tax on the amount paid for indoor tanning services.

Tax on high-cost insurance. The Senate bill would impose a 40 percent nonrefundable excise tax on group insurers if the aggregate value of applicable employer-sponsored health coverage exceeds an inflation-adjusted \$23,000 for family coverage (\$8,500 for individual coverage) beginning in 2013. Designed principally to limit so-called “Cadillac plans,” the excise tax for these high-end policies would be imposed pro rata on issuers. For self-insured plans, the plan administrator (including employers that act as plan administrators) would pay the excise tax. Transition relief would be available for coverage in 17 high-cost states for 2013, 2014, and 2015. The excise tax is estimated to generate approximately \$200 billion over ten

years. Penalties would apply for failure to properly calculate the excess benefit, barring certain exceptions.

Additional Medicare tax. The Senate bill would impose an additional 0.9 percent Medicare payroll tax on individual earned income over \$200,000 (\$250,000 for joint filers). Self-employed individuals would also be liable for the additional tax. The payroll tax is projected to raise \$53 billion in additional revenue over ten years.

Comment: *The House bill imposes a surtax of 5.4 percent on married couples filing jointly and surviving spouses with modified adjusted gross income that exceeds \$1 million. The same 5.4 percent rate would apply to other taxpayers with modified AGI exceeding \$500,000, including estates and trusts. The surtax is estimated to raise \$460.5 billion over ten years.*

Market Reforms

Under the Senate bill, for plan years beginning on or after January 1, 2014, new requirements would include the following:

- Elimination of preexisting condition exclusions;
- Premium rating allowed by individual or family coverage, geographic area, age (limited to a 3-1 ratio), and tobacco use (limited to a 1.5-1 ratio);
- Guaranteed issue and renewability; and a
- Blanket prohibition against discrimination because of health status.

Comment: *The House version contains similar measures, although it would limit age rating to 2:1 (i.e., premiums for older adults may be twice as high as premiums for younger individuals).*

Benefit explanations. The Senate bill requires group health plans to provide accurate summaries of benefits and coverage information that do not exceed four pages in length, and utilize terminology understandable by the average enrollee. The Department of Health and Human Services would have one year from enactment to develop standards for the summary, and benefit plans would have one year after that to provide the new summaries to participants.

Comment: *The House bill has a similar provision, though it does not take effect until 2018 for many existing employer-based plans.*

Medicare and Medicaid

The Senate bill adds several provisions related to the link between quality outcomes and payments under Medicare. It also adjusts reimbursement for most types of Medicare providers to improve payment accuracy. It adjusts Medicare Advantage payments to be more in line with Medicare fee-for-service payments. The bill makes a variety of changes in Medicare Part D, including an attempt to close the “donut hole” for prescription drug coverage.

The Senate bill expands both access to Medicaid, as well as the types of services that are covered under Medicaid, including preventive services and long-term care. Additional revenue is allocated for specific maternal and child health services.

The bill includes provisions to increase the program integrity of both Medicare and Medicaid. Below are highlights of the Medicare and Medicaid portions of the bill.

Medicare

Value-based purchasing. The legislation establishes a value-based purchasing (VBP) program for hospitals

Senate and House Bill Similarities

The Senate bill approved on Dec. 24 shares many similar or identical provisions with the House bill approved on Nov. 7. These provisions include:

- a productivity adjustment for the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities beginning in various fiscal years;
- reduction in hospitals' Medicare Disproportionate Share Hospital (DSH) payments to reflect lower uncompensated care costs relative to increases in the number of insured;
- elimination of coinsurance and deductibles for preventive health services under Medicare;
- reduction of \$500 in the “donut hole in 2010 for Medicare Part D prescription drug benefit plans;
- establishment of a new CMS Center for Medicare and Medicaid Innovation;
- authorization for physician assistants to order skilled nursing care services

starting in 2013. A portion of a hospital's Medicare payment will be linked to the hospital's performance on quality measures related to common and high-cost conditions, such as cardiac, surgical, and pneumonia care. The Secretary of HHS would be required to develop a VBP plan by 2012 on moving skilled nursing facilities and home health agencies into a value-based purchasing payment system. By 2016, VBP pilot programs should be implemented for psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, PPS-exempt cancer hospitals, and hospice programs.

Quality reporting. The Secretary of HHS would be required to develop quality measure reporting programs for long-term care hospitals, rehabilitation hospitals, hospice programs, and PPS-exempt cancer hospitals.

Hospital-acquired conditions. Starting in fiscal year 2015, hospitals in the top 25th percentile of rates of hospital-acquired conditions for certain high-cost procedures would be subject to a payment penalty.

Readmissions reduction. Beginning in fiscal year 2012, CMS would adjust payments paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of preventable Medicare readmissions for acute myocardial infarction, heart failure, and pneumonia patients.

Ambulatory surgical centers. The legislation calls for the development of a plan to implement a value-based purchasing program for payments under the Medicare program for ambulatory surgical centers.

Medicare payments for frontier states. The legislation would increase Medicare payments to providers in any state where at least 50 percent of the counties are "frontier counties," those having a population density less than six people per square mile.

Comment: According to the Congressional Budget Office, five states qualify as frontier states: Montana, North Dakota, South Dakota, Utah and Wyoming.

Rural healthcare. The legislation extends several existing statutes related to improving Medicare payments to providers in rural areas. The existing "hold harmless" provisions relating to adjustments that would offset the effect of the outpatient prospective payment system on rural hospitals and sole community hospitals with more than 100 beds would be extended through the end of fiscal year 2010. The Rural community Hospital Demonstration Program and the Medicare-dependent hospital program would both be extended. The temporary adjustment to inpatient payments to low-volume hospitals would extend through FY 2012.

Payment accuracy. Home health payments would be rebased starting in 2013 based on an analysis of the current mix of services and intensity of care provided to home health patients. Hospice claim forms and cost reports would have to be updated by 2011. The Secretary of HHS would be required to regularly review the physician fee schedule for services paid by Medicare, with a particular emphasis on services that have experienced high growth rates. The legislation modifies the equipment utilization factor for advanced imaging services. It also extended hospital wage index reclassifications through the end of FY 2010.

Independent Medicare Advisory Board. This board would be required to present Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. The Board's proposals will automatically take effect unless Congress approves legislation with similar savings.

Medicare Part B

Part B payments. The legislation extends a floor on geographic adjustments to the work portion of the physician fee schedule until the end of 2010. It extends the exceptions process for Medicare therapy caps until Dec. 31, 2010. It also extends payments for the technical component of certain physician pathology services; bonus payments for ambulance services in rural areas; and the physician fee schedule mental health add-on. It also increases the payment rate for certified nurse midwives for covered services to the full rate that a physician would receive for performing the same service.

Comment: The Senate bill as introduced included a provision to replace the scheduled 21 percent payment reduction under the physician fee schedule for 2010 with a 0.5 percent increase. This provision was removed before the Senate took its final vote. However, the physician pay cut has been delayed at least until March 1, 2010, under a provision included in the defense appropriations bill for 2010.

Physician quality reporting initiative. The PQRI program, which provides financial incentives to physicians who report quality data to CMS, would be extended through 2014. The Secretary of HHS also would be required to develop and implement a system that will adjust Medicare physician payments based on the quality and cost of the care they deliver.

Prevention services. The legislation provides coverage, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services.

It also would waive beneficiary coinsurance requirements for most preventive services.

Comment: *A report cited by the Senate Finance Committee noted that elderly patients are price-sensitive and that a \$10 co-payment increase led to a 20 percent decline in physician office visits.*

Part B premiums. For beneficiaries who pay a higher Part B premium, income thresholds are frozen at 2010 levels until 2019.

Medicare Part C

Payments. The legislation sets Medicare Advantage payments based on the average of the bids from MA plans in each market, rather than on a statutorily set benchmark rate.

Comment: *Using plan bids to set MA plan rates would encourage plans to compete more directly on the basis of price and quality rather than on the level of extra benefits offered to enrollees. Further, since plan bids are usually lower than benchmark rates, this change would provide cost savings to the Medicare program.*

Benefit protection. MA plans would be prohibited from charging beneficiaries cost sharing that is greater than what is charged under Medicare fee-for-service.

Annual enrollment. The annual enrollment periods for beneficiaries will be simplified; MA enrollees will be allowed to disenroll and return to fee-for-service Medicare each year from January 1 to March 15.

Special needs plans. MA special needs plans for dual eligible, frail individuals would be extended through 2013.

Medicare Part D

“Donut hole” fix. Drug manufacturers would be required to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. The initial coverage limit in the standard Part D benefit would be increased by \$500 for 2010.

Comment: *The donut hole was put in place when Medicare Part D was created in 2003. Its purpose was political, not practical. Congress had to make the legislation that enacted Medicare Part D budget neutral and requiring a large “gap” in prescription drug coverage,*

where the government paid nothing and the beneficiary shouldered the entire cost of prescription drugs, was one of the ways that the legislation could pass scrutiny by the Congressional Budget Office.

Part D premium subsidy and cost sharing. The legislation would remove the Part D premium subsidy for beneficiaries with incomes above the Part B income threshold. Cost sharing for beneficiaries receiving care under a home- and community-based waiver would be eliminated. Several changes are made in the determination of the low-income subsidy.

Medicaid

Expanded eligibility. States would have the option starting in 2014 to expand Medicaid eligibility to non-elderly, non-pregnant individuals who are not otherwise eligible for Medicare, with incomes up to 133 percent of the federal poverty level (FPL). From 2014 through 2016, the federal government would pay 100 percent of the cost of covering newly eligible individuals.

Comment: *The House bill has a similar provision, although with the House bill, the income limit is 150 percent of the FPL. Under current law, the mandatory minimum Medicaid income level has ranged from 11 percent to 68 percent of FPL, although in some states parents with incomes of up to 200 percent of FPL have been made eligible for Medicaid through state plan amendments.*

Children’s Health Insurance Program. States would be required to maintain income eligibility levels for CHIP through the end of fiscal year 2019.

Enrollment changes. Individuals could apply for or enroll in Medicaid, CHIP, or an insurance plan offered by one of the new state-based Exchanges through one state-run website. Hospitals would be allowed to provide Medicaid services during a period of presumptive eligibility of all Medicaid eligibility categories.

Expansion of services. Medicaid would cover services provided by free-standing birth centers. States would have the option of offering community-based attendant services to disabled Medicaid beneficiaries who would otherwise need institutional care. State also could provide more home- and community-based services through a state plan amendment rather than a waiver. The current state option to provide certain diagnostic and preventive services would be expanded to include specific clinical preventive services and immunizations.

Comment: States that provide additional preventive services and vaccines would receive an increased federal medical assistance percentage of one percentage point for these services.

Prescription drug rebate. The flat rebate for single source and innovator multiple source outpatient prescription drugs would increase from 15.1 percent to 23.1 percent. The basic rebate for multi-source, non-innovator drugs would increase from 11 percent to 13 percent.

DSH payments. A state's disproportionate share hospital allotment will be reduced by 50 percent once its rate of uninsurance decreases by 45 percent.

Health care quality. The Secretary of HHS would be required to develop a set of quality measures for Medicaid eligible adults that is similar to the quality measures under CHIP. The Secretary also would be required to develop a list of healthcare-acquired conditions for which Medicaid will not reimburse providers.

Comment: The definition of healthcare-acquired condition under Medicaid would be similar to the existing definition of hospital-acquired condition under Medicare, but the Medicaid definition would not be limited to conditions acquired in a hospital.

Maternal and child health services. The legislation provides funding for maternal, infant and early childhood home visiting programs; research and education on post-partum depression; and abstinence and contraception education for adolescents.

Medicare and Medicaid

Dual eligibles. The legislation requires the Secretary of HHS to establish a federal Coordinated Health Care Office responsible for better coordinating health care for individuals who are eligible for both Medicare and Medicaid.

Center for Medicare and Medicaid Innovation. The legislation would establish within CMS a new Center for Medicare and Medicaid Innovation responsible for research, development, testing, and implementation of innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to Medicare and Medicaid patients.

Accountable Care Organizations. ACOs that meet designated quality of care targets and reduce the cost of their patients health care spending would be rewarded with a share of the Medicare savings they achieve.

Comment: ACOs may include groups of health care providers such as physician groups, hospitals, nurse practitioners, and physician assistants.

Medicare demonstration projects. The Senate bill includes several demonstration projects relating to Medicare, including projects:

- to test a payment incentive and service delivery system that uses physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes;
- to extend the gainsharing demonstration project aimed at evaluating arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries;
- to improve the demonstration project designed to allow rural health care providers to test new models for the delivery of health care;
- to allow patients who are eligible for hospice care to receive all other Medicare covered services at the same time;
- to increase graduate nurse education training;
- to implement a national independent monitoring program to conduct oversight of interstate and large intrastate nursing home chains;
- to conduct facility-based projects on culture change and the use of information technology in nursing homes;
- to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries;
- to test the impact of direct payments for certain complex laboratory tests.

Medicaid demonstration projects. The Senate bill includes several demonstration projects relating to Medicaid, including projects:

- to allow states to adjust their current pay structure for safety net hospitals from a fee-for-service model to a global capitated payment structure;
- to study the use of bundled payments for hospital and physician services;
- to allow qualified pediatric providers to receive payments as accountable health organizations
- to establish a Medicaid emergency psychiatric demonstration project;
- to develop a comprehensive model for reducing childhood obesity;
- to provide access to comprehensive health care services to the uninsured at reduced fees.

Program Integrity

Program integrity. The legislation prohibits physician-owned hospitals that do not have a provider agreement prior to Feb. 1, 2010, from participating in Medicare. Drug, medical device, biological, and medical supply manufacturers would be required to report transfers of value made to any physician, medical practice, group practice, or teaching hospital.

Nursing home integrity. Skilled nursing facilities and nursing homes would be required to disclose specific ownership information. The Secretary of HHS would be required to modify cost reports for SNFs to require reporting of expenditures on wages and benefits for direct care staff.

Civil money penalties. Civil money penalties could be reduced by 50 percent for certain facilities that self-report and promptly correct deficiencies within 10 calendar days of imposition.

Provider screening. The legislation would put in place specific screening and disclosure requirements for providers and suppliers participating in Medicare, Medicaid, and CHIP.

National fraud and abuse data collection. HHS would be required to maintain a national health care fraud and abuse data collection program for reporting specific adverse actions taken against health care providers, suppliers, and practitioners. The Healthcare Integrity and Protection Databank would be terminated and its information transferred to the National Practitioner Data Bank.

Claims submission. Beginning January 2010, the maximum period for submission of Medicare claims would be reduced to not more than 12 months.

Expansion of RAC program. The recovery audit contractor program would be expanded to state Medicaid programs.

Prevention

National council and public health fund. The legislation establishes a national council consisting of representatives from the departments of HHS, Agriculture, Education, Labor, Transportation and others, which is charged with establishing a national prevention and health promotion strategy. It also establishes a prevention and public health investment fund to provide national investment in prevention and public health programs to improve health and restrain the rate of growth in health care spending.

Clinical preventive services. The legislation authorizes a grant program for the development of school-based health clinics. It establishes an oral healthcare prevention education program.

Chronic disease. The legislation provides for the award of grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. The Centers for Disease Control and Prevention would provide grants to states and local health departments to conduct pilot programs on the 55-to-64 year old population to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease receive clinical treatment to reduce risk.

Nutrition labeling on menus. Restaurants that are part of chains of 20 or more restaurants would be required to disclose calories on the menu board and, in written form, available to customers upon request, additional nutritional information.

Healthcare Workforce

National healthcare workforce commission. This commission would be charged with providing comprehensive, unbiased information to Congress and the President on how to align federal healthcare resources with national needs. States would be eligible for grants to develop a healthcare workforce at the local level.

Student loan programs. The legislation modifies existing federally supported student loan programs for medical students; increases loan amounts and updates the years for nursing schools to establish and maintain student loan funds; establishes a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services in underserved areas; offers loan repayment for public health students who work for at least three years at a federal, state, local, or tribal public health agency; and offers loan repayment for allied health professionals employed at public health agencies in underserved areas.

Training. The legislation provides for training in family medicine, general internal medicine, general pediatrics, and physician assistantship. Funding also is provided to establish new training opportunities for direct care workers providing long-term care. The legislation authorizes funding for geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools and family caregivers. It also provides grants for mental and behavioral health education; advanced

nursing education; nurse training and retention; and community health workforce promotion.

Comment: *As noted above, the legislation directs more federal funding toward primary care and preventive services, while expanding the number of people who will have health insurance from public or private sources. More primary care providers—doctors, nurses, physician assistants, etc.—are necessary to make sure that there are adequate resources for providing basic primary and preventive care.*

Miscellaneous Provisions

Biologics Price Competition and Innovation Act.

The Secretary of HHS would be required to establish a process to license a biological product that is biosimilar to or interchangeable with a licensed biologic product.

Community Living Assistance. The legislation establishes a national voluntary insurance program for purchasing community living assistance services and support, i.e., long-term care assistance.

Indian healthcare. The legislation prohibits cost sharing for Indians enrolled in a qualified health benefit plan obtained through an Exchange. It also authorizes appropriations for the Indian Health Care Improvement Act for 2010 and beyond. The legislation also incorporates the text of S. 1790, the “Indian Health Care Improvement Reauthorization and Extension Act of 2009.” Among other things, this legislation requires a federal health care program to accept an Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization entity as a provider eligible to receive payment under the program for services furnished to an Indian on the same basis as any other qualified provider.

Demonstration projects. The Senate bill includes several demonstration projects relating to public health, preventive services, tort reform, and other health care issues, including projects:

- to give grants to academic institutions to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals’ clinical education;
- to provide at-risk populations who utilize community health centers with a comprehensive risk-factor assess-

ment and an individualized wellness plan designed to reduce risk factors for preventable conditions;

- to award grants to establish training programs for alternative dental health care providers to increase dental health services in underserved areas;
- to provide aid and supportive services to low-income individuals for health care education and training, in particular for occupations that are likely to experience labor shortages;
- to develop alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.

Studies. The legislation requires a number of federal agencies to conduct studies on different aspects of the Medicare and Medicaid programs, including:

- an HHS study on whether certain urban hospitals should qualify for the Medicare dependent hospital program;
- a MedPAC study on the adequacy of Medicare payments for health care providers serving in rural areas;
- an HHS study whether existing cancer hospitals that are exempt from the inpatient prospective payment system have costs under the outpatient prospective payment system (OPPS) that exceed costs of other hospitals, and to make an appropriate payment adjustment under OPPS based on that analysis;
- an HHS study on the need for additional Medicare payments for certain urban Medicare-dependent hospitals paid under the inpatient prospective payment system;
- an HHS OIG study comparing prescription drug prices paid under the Medicare Part D program to those paid under state Medicaid programs;
- a Government Accountability Office study on the utilization of and payment for Medicare covered preventive services, the use of health information technology in coordinating such services, and whether there are barriers to the utilization of such services;
- a GAO study and report to Congress on coverage of vaccines under Medicare Part D and the impact on access to those vaccines;
- a GAO study on the Five-Star Quality Rating System for nursing homes which would include an analysis of the systems implementation and any potential improvements to the system.

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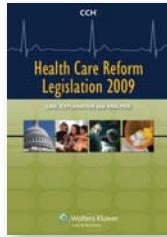
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